

Rev.01/02

PRECEPTOR CONTINUING EDUCATION CREDIT APPLICATION

Please complete and return this application **with a \$15 fee** to the address listed below. This information is required in accordance with CCR, Title 16, Section 3151(d) and B & P 3920 and 3921.

PLEASE PRINT CLEARLY IN INK OR TYPE

LAST NAME OF ADMINISTRATOR IN TRAINING	(FIRST)	(MIDDLE)	
ADDRESS (STREET AND NUMBER)	(CITY)	(STATE)	(ZIP CODE)
EFFECTIVE DATE OF AIT PROGRAM	ENDING DATE OF AIT PROGRAM	NUMBER OF CE HOURS CLAIMED	
FACILITY NAME WHERE TRAINING WAS CONDUCTED	FACILITY TELEPHONE NUMBER	FACILITY FAX NUMBER	
FACILITY ADDRESS (STREET AND NUMBER)	(CITY)	(STATE)	(ZIP CODE)
NAME OF PRECEPTOR		NHA LICENSE NO.	
ADDRESS (STREET AND NUMBER)	(CITY)	(STATE)	(ZIP CODE)

PLEASE NOTE:

One hour of credit shall be awarded for each week in which a licensee serves as the preceptor in an approved administrator in training program, regardless of the number of administrators in training concurrently in training. No more than twenty classroom hours may be acquired pursuant to this subsection during a two-year licensing period.

☐ \$15 Fee included

I/We certify under penalty of perjury that the information obtained in this document is both true and correct.

Signature of Preceptor

Date

FOR OFFICE USE ONLY	
<input type="checkbox"/> Cashier #: _____	<input type="checkbox"/> Cashier Date: _____
DATE APPROVED _____	NHAP STAFF INITIALS _____
INFORMATION VERIFIED FROM TRAINING REPORT <input type="checkbox"/> YES <input type="checkbox"/> NO	
NO. OF HOURS APPROVED _____	APPROVAL NO _____

Return this form to:
Nursing Home Administrator Program
P.O. Box 997416, MS 3302, Sacramento, CA 95899-7416